

SECTION I - TO BE COMPLETED BY N.Y.P.D.

Prisoner's Name (Last, First, M.I.) (Print)

CORTES, GONZALO

Address

ASTORIA, NY

Zip Code

AGE

44

Sex  
M

Telephone No.

Arresting Officer: Rank (Print) Name (Last, First, M.I.)

P.O. SMITH, MATTHEW

Signature

Shield No.

9407

Tax Reg. No.

952253

Command

169

Arrest No.

Q13639344

Cmd. Of Arrest

115

Charge

PL 12000, PL 240.26

Escort Officer: Rank (Print) Name (Last, First, M.I.)

P.O. SMITH, MATTHEW

Signature

Shield No.

9407

Tax Reg. No.

952253

Command

169

Prisoner Requests/Requires Medical Aid

☒ Yes ☐ No

Prisoner Refused Medical Aid

☐ Yes ☒ No

Date

7/1/13

Time

0735

Prisoner's Signature

Transported To Hospital (Name)

EGH

Date

7/1/13

Time

0735

Via Patrol

Weapon #

RMP #

IACR #

PCR #

Operator Rank (Print) Name (Last, First, M.I.)

Returned From Hospital

Date Time

Attempted Suicide

☐ Yes ☒ No

Nature Of Illness/Injury

Gun to shoulder

If Injury

☒ Old ☐ New

Restraining Devices Used

☐ Yes ☐ No

E. S. U. Responded

☐ Yes ☒ No

If Yes, Respondent's Rank (Print) Name (Last, First, M.I.)

Prescription Medication

☐ Yes ☒ No

Prescription Number And Name Of Physician

Pharmacy Phone No.

Property Clerk Invoice No./Cms

Possessed At Arrest

☒ Yes ☐ No

Remarks:

SMALL CUT TO HAND, COMPLAINT OF SHOULDER PAIN PRIOR POLICE CONTACT

Prisoner Refused Medical Aid In The Field ☐ Yes ☒ No  
Prisoner Refused Medical Aid At The Command ☐ Yes ☒ No  
Prisoner Refused Medical Aid Within The Court Section ☐ Yes ☐ No  
Recommend Prisoner Be Separated From General Population ☐ Yes ☒ No

E.M.S. Field Personnel: Print Name (Last, First, M.I.)  
Shield #  
Date  
Time  
Refer To Hospital Emergency Room ☐ Yes ☒ No

E.M.S. Court Section: Print Name (Last, First, M.I.)  
Shield #  
Date  
Time  
Refer To Hospital Emergency Room ☐ Yes ☒ No

NYPD Supervisor/Desk Officer: Rank (Print) Name (Last, First, M.I.)  
Signature  
Cmd. Of Arrest/Court Section  
Date  
Time

SECTION II - TO BE COMPLETED BY HOSPITAL MEDICAL STAFF

Admitted To Hospital ☐ Yes ☐ No  
Suicide Watch Recommended By Hospital Staff ☐ Yes ☐ No  
Transfer To Psychiatric Hospital Recommended By Hospital Medical Staff ☐ Yes ☐ No  
Medication Prescribed ☐ Yes ☐ No  
Medication To Be Taken As Prescribed ☐ Yes ☐ No

Medication To Travel With Prisoner ☐ Yes ☐ No  
Refer To Psychiatric Hospital ☐ Yes ☐ No

Print Name (Last, First, M.I.)  
Signature  
Title  
Date  
Time

NYPD Court Section Supervisor: Rank (Print) Name (Last, First, M.I.)  
Signature  
Court Section  
Date  
Time

Received By Department Of Correction: Rank (Print) Name (Last, First, M.I.)  
Signature  
Shield #  
Date  
Time

DISTRIBUTION: 1. WHITE, 2. BLUE, 3. PINK - DEPT. OF CORRECTION  
4. BUFF - CMD. OF ARREST  
5. GREEN - ARRAIGNING JUDGE  
(Receipt will be obtained by Escorting Officer on PINK COPY and returned to COURT SECTION facility. Upon receipt of PINK COPY, COURT SECTION Supervisor will remove BUFF COPY from FILE and forward it to COMMAND OF ARREST FOR FILE.)

NOTE: A PHOTO COPY OF THIS FORM MAY BE PROVIDED UPON REQUEST TO HEALTH AND HOSPITALS CORPORATION (HHC) PERSONNEL.